Required Screening Questions

For individuals who are 18 years of age and older.

1. Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.

Choose any/all that are new, worsening, and not related to other known causes or medical conditions.

Fever and/or chills Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher	☐ Yes	☐ No
Cough or barking cough (croup) Continuous, more than usual, making a whistling noise when breathing, not related to other known causes or conditions (for example, asthma, post-infectious reactive airways, COPD)	☐ Yes	☐ No
Shortness of breath Out of breath, unable to breathe deeply, not related to other known causes or conditions (for example, asthma)	☐ Yes	☐ No
Decrease or loss of smell or taste Not related to other known causes or conditions (for example, allergies, neurological disorders)	☐ Yes	☐ No
Sore throat Not related to other known causes or conditions (for example, seasonal allergies, acid reflux)	☐ Yes	☐ No
Difficulty swallowing Painful swallowing, not related to other known causes or conditions	☐ Yes	☐ No

Pink eye Conjunctivitis, not related to other known causes or conditions (for example, reoccurring styes)	☐ Yes	☐ No
Runny or stuffy/congested nose Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather)	☐ Yes	☐ No
Headache that's unusual or long lasting Not related to other known causes or conditions (for example, tension-type headaches, chronic migraines)	☐ Yes	☐ No
Digestive issues like nausea/vomiting, diarrhea, stomach pain Not related to other known causes or conditions (for example, irritable bowel syndrome, menstrual cramps)	☐ Yes	☐ No
Muscle aches that are unusual or long lasting Not related to other known causes or conditions (for example, a sudden injury, fibromyalgia)	☐ Yes	☐ No
Extreme tiredness that is unusual Fatigue, lack of energy, not related to other known causes or conditions (for example, depression, insomnia, thyroid dysfunction)	☐ Yes	☐ No
Falling down often For older people	☐ Yes	☐ No

For individuals who are less than 18 years of age.

1. Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.

Symptom	Yes	No
Fever and/or chills Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher	☐ Yes	☐ No
Cough or barking cough (croup) Continuous, more than usual, making a whistling noise when breathing, not related to other known causes or conditions (for example, asthma, post-infectious reactive airways)	☐ Yes	☐ No
Shortness of breath Out of breath, unable to breathe deeply, not related to other known causes or conditions (for example, asthma)	☐ Yes	☐ No
Decrease or loss of smell or taste Not related to other known causes or conditions (for example, allergies, neurological disorders)	☐ Yes	☐ No
Sore throat or difficulty swallowing Painful swallowing, not related to other known causes or conditions (for example, seasonal allergies, acid reflux)	☐ Yes	☐ No
Runny or stuffy/congested nose Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather)	☐ Yes	☐ No

Headache that's unusual or long lasting Not related to other known causes or conditions (for example, tension-type headaches, chronic migraines)	☐ Yes	☐ No
Nausea, vomiting and/or diarrhea Not related to other known causes or conditions (for example, irritable bowel syndrome, anxiety in children, menstrual cramps)	☐ Yes	☐ No
Extreme tiredness that is unusual or muscle aches Fatigue, lack of energy, poor feeding in infants, not related to other known causes or conditions (for example, depression, insomnia, thyroid dysfunction, sudden injury)	☐ Yes	☐ No

2. Have you travelled outside of Canada in the last 14 days?

If you are an essential worker who crosses the Canada-US border regularly for work, select "No".

☐ Yes ☐ No

3. In the last 14 days, has a public health unit identified you as a close contact of someone who currently has COVID-19?

☐ Yes ☐ No

4. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?

☐ Yes ☐ No

5. In the last 14 days, have you received a COVID Alert exposure notification on your cell? If you already went for a test and got a negative result, select "No."

☐ Yes ☐ No